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Care Partnership; Recognition of Reciprocity of Care in Aged Care

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Abstract

Reciprocity of care was conceptualised by Janssen and MacLeod as a means to which care outcomes may be improved where a two way relationship exists between the patient and care provider. The issues in the healthcare workplace are escalating and the future model of care is uncertain. In residential aged care, 'person centred care' has become the 'gold start' model of care however; it had limited implementation possibly due to its resource intensive needs and the limited capacity of clinical leadership in the sector. This paper, considers the future relevance of a 'care partnership'. A 'care partnership' suggests that both the patient and the care provider have needs that may be largely unsupported in a traditional one way provision of services and care. By acknowledging that the patient can support the care provider and vice versa, possibly the burnout, stress and motivation for development could be reduced, therewith possibly supporting a more sustainable and beneficial outcome to care.

Keywords: End of life; Palliative care; Aged care; Workforce; Care relationship; Case management

Introduction

A 'care relationship' is a unique connection between a client/resident/patient and that of a care provider. A care provider is trained to provide care, that is a one way provision of services, knowledge, empathy and passion for what is considered appropriate within a professional boundary. Janssen and MacLeod [1] argued for potential chasm in healthcare professionalism; reciprocity of care. The need for effective and meaningful care is possibly more about the relationship and the humanisation of care, rather than the service and care delivery. Reciprocity of care, which whilst highlighted by Janssen and MacLeod [1] around end of life, should be considered within the wider context of healthcare.

One must wonder why so many 'under paid', 'under resourced' and largely 'unrecognised' people (professionals and care workers) work in health. One could argue that the primary driver is this reciprocity of care; the search to give back, personal reward, to develop and grow as an outcome of connections formed with patients and their families.

Discussion

Janssen and MacLeod [1] develop a strong argument for consideration to the impact of terminally ill patients' experiential satisfaction with care and their level of engagement in treatment [2]. They refer to the possibility of a care giver and patient being morally obliged to provide care, to reciprocate care, as dependant on their capacity [3]. This co-existence provides for some level of dependence and vulnerability to aid the development of a 'care partnership'. It is this human relationship that is invaluable and largely under recognised [1]. How much could this 'care partnership' contribute to a more effective and efficient treatment or intervention?

Care Partnership

A 'care partnership' concept potentially changes the way one would approach 'care'. We have long strived for a person centred model of care to which a care provider strives to ensure the patient is offered choice to engage in all elements of their care planning and evaluation. A person centred model has been well regarded for its beneficial and effective outcomes [4,5]; struggles to be fully implemented where training and clinical leadership is less than adequate. Could this be more successful when a focus on partnership is put forward whereby the patient and care provider strive to understand needs more fully? Is this what society would want, or will the future of healthcare continue to drive a one way service and care provision model? One could hypothesize that the latter is more predictable however the earlier would be more sustainable.

The workforce shortages, burn out and occupational stress in healthcare are common areas of concern internationally [6-9]. As we continue to embark on meeting the patients needs more efficiently and effectively, have we moved too far from what once was a more traditional hands on relationship that meant we understood the person more comprehensively? Health professionals rely heavily on a team to develop a picture, conceptualise the changes and map the triggers in order to de-escalate a problem, but do we have time to communicate that now and how well does that team really work? While this paper draws together more questions than answers, we should be reminded that our role as health professionals should be to continue to question, rethink and constantly evaluate not only our own processes but that of the team to which we work in.

Developing practices for palliative care in residential aged care has evolved significantly over the past decade, with particular relevance to the growing numbers of palliative care patients [10,11]. The level of intervention between acute and residential aged care varies significantly, which is predominantly in relation to the capability, available resources and funding. A patient receiving end of life care in an Australian residential aged care facility would receive a maximum of $163 per day of funding, as compared to an acute care bed getting $1,300 per day [12]. Despite similar levels of pain relief, emotional support for family and patient, and frequent care interventions. There is an obvious lack of regard for the actual needs of a patient and their families in residential aged care.

The major themes the author took from Janssen and MacLeod [1] as related to aged care included:

Respectful Relationship

Developing advanced care directives and providing more informed

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care choices, provides greater degree of professional respect. Respect develops a more informed and empathetic relationship [13]. One must question the aged care sectors' capability, given its current skill mix and funding resources due to a lack of regulated workforce and scant access to Medical Practitioners [14]. Many nurses and Medical Practitioners feel ill-prepared to respond to the needs of the dying, not only with their communication skills but also due to the lack of time and privacy [15,16]. A 'care relationship' provides a framework for engaging the patient and key stakeholder's needs, thereby possibly developing a greater level of respect.

Case Management

As society searches to be more informed and self governing, care provision has begun to respond accordingly. A collaborative care case management model provides a meaningful and consumer engagement model to develop an individual and coordinated approach to care during end of life [14]. It provides a means to which collaboration is central to the drivers of care, the level of engagement with key stakeholders, and their actual and predicted needs at key stages in their journey. An overlay is to ensure care is effective, efficient and targeted to the individual. This is dependent on a comprehensive assessment and evaluation being undertaken with skilled and competent case managers and staff, with reasonable case loads. This is underpinned by a strong organisational vision and operational measures to report against, which are largely reliant on following care pathways. Case management assists key stakeholders to have a higher level of independence and engagement in the care provided.

Reciprocity

Reciprocity and development of a care partnership is largely undocumented and under-researched in aged care. The idea of care-giving being a two ways and mutually beneficial relationship is an exciting and innovative approach to what is a very traditional service delivery model of care. A significant shift in thinking from a traditional 'person centred care' approach is needed to achieve 'care partnerships'. Transitioning not just the aged care providers, but also the community's acceptance of needing to develop a partnership will require funding, substantial leadership training, and community engagement.

Methodology

Janssen and MacLeod [1] have undertaken some thought provoking research into the need to rethink the value and impact of relationships in healthcare. The methodology of the article [1] proposes some weaknesses due to limited explanation of its methodology around; selection criteria and bias, exclusion criteria, sampling process, and reported representation of identified target sample. The analysis process was appropriate given the methodology. Data saturation was reported, despite only undertaking thirteen semi-structured interviews. Whilst limitations exist in the methodology narrative, there were significant strengths in the discussion to give credibility to the findings.

Conclusion

The concept of a 'care partnership' and the benefits from which the reciprocity of care could translate is both thought provoking and exciting. Healthcare, and in particular aged care, continues into the foreseeable future to struggle with increasing consumer demands and acuity, inadequate funding, occupational stress and workforce shortages. 'Care partnership' considers the concept that a two way care relationship could in fact be beneficial to both patient and care providers.

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